MEDICAID SERVICES MANUAL
TRANSMITTAL LETTER

May 11, 2010

MEMORANDUM

TO: CUSTODIANS OF MEDICAID SERVICES MANUAL

FROM: MARTA STAGLIANO, CHIEF, COMPLIANCE M. Stagliano

SUBJECT: MEDICAID SERVICES MANUAL CHANGES
CHAPTER 200 – HOSPITAL SERVICES

BACKGROUND AND EXPLANATIONS

Changes are being made to Medicaid Services Manual (MSM) Chapter 200 - Hospital Services to include removing language regarding coverage of inpatient respite services. New policy involves provider responsibility under federal requirements relating to benefits for mothers and newborns referenced in 203.1B.16. Modifications to Chapter 200, that do not represent a change in policy include: removing the "Reimbursement" heading and repetitive reimbursement language already specified in Chapter 700 or in the State Plan Amendment; consolidating and relocating non-reimbursement related language currently under the "Reimbursement" heading to appropriate chapter locations; clarifying policy language (e.g. when observation and emergency room services would be included in the inpatient per diem rate); and updating chapter references. Changes are effective May 12, 2010.

MATERIAL TRANSMITTED **MTL 17/10** Chapter 200 – HOSPITAL SERVICES	MATERIAL SUPERSEDED **MTL 20/03, 15/07** Chapter 200 – HOSPITAL SERVICES
Sec. 200	
Added "Health Care Quality and Compliance"	Deleted "Licensure and Certification"
Added "of those listed in the"	Deleted "of the four areas where Medicaid and"
Added "Manual,"	Deleted "policies differ as documented in"
Added "1000"	Deleted "3700"
Sec. 201.B.5	
Added "5. 29 CFR Part 2590.711 (Standards Relating to Benefits for Mothers	

and Newborns)"

Sec. 203.1
Added "mental disease"

Deleted "tuberculosis"

Sec. 203.1A.1.e
Added "Reimbursement for observation cannot exceed 48 hours."

Deleted "status"

Added "O"

Deleted "For authorization purposes, o"

Added "services"

Deleted "s"

Added "a physician writes an order for either inpatient admission, transfer to another health care facility, or discharge. Time related to the provision of medically necessary services after a physician writes the discharge order, but prior discharge, are reimbursed as long as the total time in observation does not exceed 48 hours. Inpatient admission from observation begins at the time and on the calendar date that a physician writes an inpatient admission order."

Deleted "the nurses' notes indicate the recipient left the hospital. When a recipient is admitted as an inpatient subsequent to a maximum 48 hour observation stay, a separate dated and timed physician's order, on the physician order form, is required for the inpatient admission as defined above."

Sec. 203.1A.1.f
Added "f. Military or Veteran's Hospitals"

Added "Inpatient hospital admission at a military or Veterans' hospital is not a Medicaid benefit."

Sec. 203.1A.2
Added "any in-state or out-of-state acute inpatient"

Deleted "a"

Added "(e.g. general, Critical Access, Indian Health Services, Medical Rehabilitation or Long Term Acute Care Specialty hospitals)"

Sec. 203.1A.2.d
Added "/facility"

Added "nonemergent"

Sec. 203.1A.2.f.9

Added "Per diem reimbursement amounts are based on the level of care authorized by the QIO-like vendor."

Deleted "9. Respite care (inpatient) for children in the physical and/or legal custody of the Division of Child and Family Services (DCFS) or in the Special Needs Adoption Program. A maximum of 72 hours of respite care may be authorized at a frequency of no more than every 120 calendar days may be authorized."

Sec. 203.1A.2.f.10

Added "for admission criteria"

Sec. 203.1A.2.f.11

Added "in rural or Critical Access hospital"

Sec. 203.1A.2.f.12

Added "or Medical Rehabilitation Specialty"

Deleted "to the community"

Added "or involving an overnight stay. Reference 203.1A.3, Absences"

Sec. 203.1A.2.f.13

Added "When t"

Deleted "T"

Added "insurance"

Deleted "authorization is required"

Added "is the primary payment source. Reference Chapter 100, section 104"

Sec. 203.1A.2.f.14

Added "within 30 days of the receipt of the"

Deleted ". As soon as a provider is aware or receives documentation from"

Added "EOB indicating"

Deleted "that"

Added "Reference Chapter 100, section 103.2."

Sec. 203.1A.2.g.1

Added "a direct admission from an"

Sec. 203.1A.2.g.4

Added "direct inpatient"

Deleted "al status"

Added "as part of one continuous

Deleted "the"

encounter at the same facility"	Deleted "The inpatient admission is inclusive of the emergency and observation services"
Added "an"	
Added "Emergency or observation services resulting in a direct inpatient admission on the same calendar date and at the same facility as the inpatient admission are included in the per diem inpatient hospital rate"	
Sec. 203.1A.3 Added "Absences"	Deleted "Reimbursement"
Sec. 203.1A.3.a Added "Absences from an acute hospital or Medical Rehabilitation Specialty hospital are allowed"	Deleted "General acute care facilities are reimbursed per diem rates based on the following categories/levels of care authorized by the QIO–like vendor"
Sec. 203.1A.3.a.1 Added "In special circumstances, such as when a recipient is in the hospital on a long-term basis and needs to be absent for a few hours for a trial home visit, a respite visit with parents in the case of a child, or death of an immediate family member, or"	Deleted "Medical/Surgical"
Sec. 203.1A.3.a.2 Added "Up to, but not exceeding 32 hours from a Medical Rehabilitation Specialty hospital for therapeutic reasons, such as preparing for independent living."	Deleted "Newborn Admissions"
Sec. 203.1A.3.a.3	Deleted "3. Maternity"
Sec. 203.1A.3.a.4	Deleted "4. Intensive Care Units (ICU)"
Sec. 203.1A.3.a.5	Deleted "5. Neonatal Intensive Care Unit (NICU) Level III"
Sec. 203.1A.3.a.6	Deleted "6. Trauma Level I"
Sec. 203.1A.3.a.7	Deleted "7. Administrative Days, Skilled Nursing or Intermediate level"
Sec. 203.1A.3.a.8	Deleted "8. Psychiatric/substance abuse"

Sec. 203.1A.3.b
Added "The following information must be documented in a recipient's medical record:"

Deleted "Psychiatric/Substance Abuse. Effective with service dates of July 1, 1992, general hospitals with a psychiatric and/or substance abuse unit are reimbursed an all-inclusive per diem daily rate. Effective July 1, 1994 freestanding psychiatric and/or substance abuse hospitals known as institution for mental disease (IMD) (42 CFR 435.1009) are reimbursed under the same all-inclusive per diem daily rate as a general hospital for a like service. In accordance with 42 CFR 441.13(a)(2), Nevada Medicaid will only reimburse IMD's for recipients under the age of 21 or 65 years of age or older. Reference Chapter 400, for coverage and criteria. If a recipient is initially admitted to a general hospital for acute care and is then authorized to receive psychiatric/substance abuse services, the acute care is paid at the appropriate medical/surgical per diem rate. The psychiatric and/or substance abuse treatment/service is paid at the psychiatric/substance abuse services rate for those days certified as acute care for psychiatric/substance abuse. Days certified as administrative are paid at the all-inclusive administrative day rate. General acute care hospitals are required to bill Medicaid separately for each of the two types of stays. QIO-like vendor certifies the various types of stays accordingly."

Sec. 203.1A.3.b.1
Added "1. A physician's order specifying the number of hours for the pass;"

Sec. 203.1A.3.b.2
Added "2. The medically appropriate reason for the pass prior to issuance of the pass; and"

Sec. 203.1A.3.b.3
Added "3. An evaluation of the therapeutic effectiveness of the pass when the recipient returns."

Sec. 203.1A.3.c	Deleted "c. Specialty (Rehabilitation/ LTAC) Hospitals are reimbursed an all inclusive per diem daily rate which is based on cost reimbursement."
Sec. 203.1A.3.d	Deleted "d. Take Home Drugs Take home drugs must be separately billed per the hospital's Provider 28, pharmacy, provider agreement. Reference Chapter 1200 Pharmacy Services for coverage and criteria."
Sec. 203.1A.3.e	Deleted "e. Federal Government Facilities Indian Health Services (IHS) and Tribal facilities are paid an all inclusive daily per diem rate in accordance with the most recent published federal register notice (42 CFR 136.11). Medicaid does not reimburse military or Veteran's hospitals."
Sec. 203.1A.3.f	Deleted "f. Hospitals Out-of-State Nevada Medicaid's QIO-like vendor must verify that the medical services requested for Medicaid eligible recipients are not available in Nevada. The out-of-state payment rate for inpatient care is based on one of the following criteria, whether emergency or elective in nature:"
Sec. 203.1A.3.f.1	Deleted "1. Reimbursed according to the Nevada Medicaid per diem rate as outlined under Section 203.1A(3); or"
Sec. 203.1A.3.f.2	Deleted "2. Nevada Medicaid may negotiate a rate through a letter of agreement only if an out-of-state hospital refuses to accept the rate methodology and meets the following criteria:"
Sec. 203.1A.3.f.2.a	Deleted "a. The Nevada Medicaid eligible recipient requires medical services which, if not provided within 30 calendar days, could result in severe pain, loss of life or limb, loss of eyesight or hearing, injury to self, or bodily harm to others; and"
Sec. 203.1A.3.f.2.b	Deleted "b. The specific surgery or medical procedure needed is provided or available

	only in an out-of-state hospital; and,"
Sec. 203.1A.3.f.2.c	Deleted "c. Nevada Medicaid determines the out-of-state hospital's negotiated rate to be the most cost effective rate available. The out-of-state hospital must contact the Nevada Medicaid Rate Department prior to admission to negotiate the rate."
Sec. 203.1A.3.g	Deleted "g. Critical Access Hospitals (CAH'S) For purposes of Medicaid payment, CAH's are reimbursed under Medicare's retrospective cost reimbursement (excluding psychiatric hospitals), as follows:"
Sec. 203.1A.3.g.1	Deleted "1. Inpatient hospital services which have been certified for payment by Medicaid's contracted QIO-like vendor, as specified in the contract between the two entities, upon final settlement, are reimbursed allowable costs under hospital-specific retrospective Medicaid principles of reimbursement in accordance with 42 CFR 413.30 and 413.40, Subpart C."
Sec. 203.1A.3.g.2	Deleted "2. On an interim basis, each hospital is paid for certified acute care at the lower of: 1) billed charges or 2) the rate paid to general acute care hospitals for the same service."
Sec. 203.1A.3.h	Deleted "h. Respite Care Services Medicaid may authorize acute medical or mental health hospital admissions for medically fragile children with severe and/or chronic medical problems which require specialized care, intensive medical follow-up, supportive treatment and continuous monitoring (e.g., ventilator dependent, AIDS), to provide a temporary relief interval period for their primary care givers. These children must either be in the physical and/or legal custody of the Division of Child and Family Services (DCFS) or in the Special Needs Adoption Program, where the state agrees to provide the child/recipient with a medical subsidy.

	The request for respite care must come directly from the recipient's social worker or adoptive parents. The recipient's physician must then contact the QIO-like vendor to obtain authorization for inpatient hospital admission. The QIO-like vendor will authorize the admission only if the recipient requires inpatient hospital care for respite purposes. A maximum of 72 hours of respite care may be authorized at a frequency of no more than every 120 calendar days. It is not permitted to accumulate excess available hours from one 120 calendar day period to the next. Hospitals will receive respite care reimbursement under Medicaid's hospital inpatient per diem rate. If the QIO-like vendor authorizes the stay as acute, Medicaid reimburses at the acute level of care. If the QIO-like vendor authorizes the stay at a skilled or intermediate level, Medicaid reimburses at the appropriate administrative day rate."
Sec. 203.1A.3.i	Deleted "i. Absences"
Sec. 203.1A.3.i.1	Deleted "1. In special circumstances, Nevada Medicaid may allow up to an eight hour pass from the acute hospital without denial of payment. Occasionally, a recipient who has been in the hospital on a long-term basis needs to be absent for a few hours for: a trial home visit; a respite visit with parents in the case of a child; a death in the immediate family, etc. Although not required for absences under eight hours, hospital staff must request prior authorization from the QIO-like vendor for any absences expected to last longer than eight hours."
Sec. 203.1A.3.i.2	Deleted "2. A recipient authorized by the QIO-like vendor for a stay in a comprehensive medical rehabilitation hospital or unit may go on pass from the hospital for therapeutic reasons, such as preparing for independent living. Overnight passes to go home and passes longer than

	eight hours for community or rehabilitation reasons must be prior authorized by the QIO-like vendor. Home passes may last up to, but not more than 32 hours."
Sec. 203.1A.3.i.3	Deleted "3. Any type of absence involving any hospital requires a physician's order that is medically appropriate to allow a recipient leave on pass. The therapeutic reason for the pass must be clearly documented in the recipient's medical chart prior to the issuance of the pass. Upon the recipient's return, the pass must be evaluated for therapeutic effect and documented by the hospital."
Sec. 203.1A.4 Added "and"	Deleted ", and Ryan White Care Act"
Sec. 203.1A.4.k	Deleted "k. Qualified Medicare Beneficiaries (QMBs). QMB hospital claims are paid as follows:"
Sec. 203.1A.4.k.1	Deleted "1. Payment is the lower of the Medicare deductible amount or the difference between the Medicare payment and the Medicaid per diem."
Sec. 203.1A.4.k.2	Deleted "2. Additional Medicaid reimbursement is not made when the Medicare payment exceeds the Medicaid per diem rate."
Sec. 203.1A.4.k.3	Deleted "3. Medicaid pays the Medicare deductible for each Medicare "benefit period" up to Medicaid allowable amounts not to exceed Medicare's allowable amounts. "Lifetime reserve days" are a prior resource to Medicaid."
Sec. 203.1A.4.k.4	Deleted "4. QMB claims denied by Medicare are also denied by Medicaid. A QIO-like vendor review is not conducted for Medicare/Medicaid crossover (QMB/ MED) admissions unless acute days have been exhausted and/or there has been a termination of Medicare benefits and the

	patient is/was at an acute or administrative day level of care. Medicaid authorization is provided for acute and administrative days only. A provider must notify the QIO-like vendor whenever there is a reason to believe that Medicare coverage has been exhausted. When requesting a QIO-like vendor review, the provider must attach a copy of the Medicare Explanation of Benefits (EOB) (if obtained from Medicare) or other supporting documentation that clearly indicates that acute care hospital days have been exhausted. If Medicare benefits are exhausted, prior authorization from Medicaid's QIO-like vendor must be obtained within 30 calendar days of the receipt of the Medicare EOB. Reference Chapter 100, Section 103."
Sec. 203.1B.2.2 Added "Health Care Quality and Compliance"	Deleted "Licensure and Certification"
Sec. 203.1B.15 Added "A provider must:"	Deleted "Any request to the QIO-like vendor for this authorization should be accompanied by a copy of the Medicare Explanation of Benefits (MEOB)."
Sec. 203.1B.15.a Added "a. Notify the QIO-like vendor whenever there is a reason to believe that Medicare coverage has been exhausted."	
Sec. 203.1B.15.b Added "b. Attach a copy of the Medicare Explanation of Benefits (EOB) (if obtained from Medicare) or other supporting documentation that clearly indicates that acute care hospital days have been exhausted when requesting a QIO-like vendor review."	
Sec. 203.1B.15.c Added "c. Obtain prior authorization from Medicaid's QIO-like vendor in accordance with 203.1A.2.f.15."	

Added "QMB claims denied by Medicare are also denied by Medicaid."

Sec. 203.1B.16
Added "16. A provider must allow a recipient receiving maternity care or a newborn infant receiving pediatric care to remain in the hospital for no less than 48 hours after a normal vaginal delivery or 96 hours after a cesarean section delivery except when an attending physician makes a decision to discharge a mother or newborn infant prior to these timeframes."

Sec. 205.1
Added "PROVIDER SPECIFIC INFORMATION"

Deleted "POLICY RESOURCES"

Sec. 205.1.1
Added "1. Medicaid Services Manual Chapters:"

Added "Chapter 300 Radiology Services"

Added "Alcohol/"

Added "ies"

Added "Chapter 700 Rates and Cost Containment"

Added "Chapter 800 Laboratory Services"

Added "Chapter 900 Private Duty Nursing"

Added "Chapter 1100 Ocular Services"

Added "Chapter 1200 Prescribed Drugs"

Added "Chapter 1300 DME, Disposable Supplies and Supplements"

Added "Chapter 1400 Home Health Agency"

Added "Program"

Deleted "1."

Deleted "2."

Deleted "3."

Deleted "y Services"

Deleted "4."

Deleted "Services"

Deleted "5."

Deleted "("

Deleted ")"

Deleted "6."

Deleted "7."

Deleted "Medicaid Recipient"

Deleted "8."

Deleted "Surveillance and Utilization Review Section"

Added "Chapter 1600 Intermediate Care for the Mentally Retarded"	Deleted "9."
	Deleted "10."
Added "Chapter 1700 Therapy"	
Added "Chapter 1800 Adult Day Health Care"	
Added "Chapter 2400 Comprehensive Outpatient Rehabilitation (COR) Services"	
Added "Chapter 2500 Case Management"	
Added "Chapter 2800 School Based Child Health Services"	
Added "Chapter 2900 Mental Health Rehabilitative Treatment Services"	
Added "Chapter 3200 Hospice"	
Added "Program Integrity"	
Added "Chapter 3500 Personal Care Services Program"	
Sec. 205.1.2	
Added "2. Nevada Check Up Manual"	Deleted "11."
Added "1000"	Deleted "3700"
Added "Program"	
Sec. 205.1.3	
Added "3. Initial and ongoing eligibility for Medicaid benefits are determined by the Eligibility Specialist as set forth in the Division of Welfare and Support Services District Offices' "Eligibility and Payments Manual"."	
Sec. 205.2	
Added "FIRST HEALTH SERVICES CORPORATION"	Deleted "CONTACTS"
Sec. 205.2.A	
Added "Provider Relations Department First Health Services Corporation PO Box	Deleted "Division of Welfare and Support Services District Offices"

30042 Reno, NV 89520-3042 Toll Free number within Nevada: (877) NEV-FHSC (638-3472)"	
Sec. 205.2.B Added "Prior Authorization Department First Health Service Corporation Nevada Medicaid and Nevada Check Up Health Care Maintenance (HCM) 4300 Cox Road Glen Allen, VA 23060 Telephone number: (800) 525-2395 Fax number: (866) 480-9903"	Deleted "Initial and ongoing eligibility for Medicaid benefits are determined by the Eligibility Specialist as set forth in the Division of Welfare and Support Services District Offices' "Eligibility Payments Manual."
Sec. 205.2.C Added "Web announcements, billing manuals and guidelines, forms, provider enrollment, and pharmacy information can be found at http://nevada.fhsc.com."	Deleted "Fiscal Agent"
Sec. 205.2.D	Deleted "D. State Offices State offices in Carson City may be telephoned long distance free of charge (within Nevada only) by dialing 1-800-992-0900 and asking the State Operator for the specific office:"
Sec. 205.2.D.1	Deleted "1. Nevada Division of Health Care Financing and Policy Nevada Medicaid Office 1100 E William Street Suite 102 Carson City, Nevada 89701 Telephone: (775) 684-3600"
Sec. 205.2.D.2	Deleted "2. Nevada State Health Division Bureau of Licensure and Certification 1550 East College Parkway, Suite 158 Carson City, Nevada 89706 Telephone: (775) 687-4475."
Sec. 205.2.D.3	Deleted "3. Nevada Division of Health Care Financing and Policy Medicaid District Offices are listed in various Medicaid pamphlets. Local telephone numbers are: Carson City (775) 687-3651 Elko (775) 753-1191 Las Vegas – Belrose (702) 486-1550 Reno – Bible Way (775) 688-2811"
Sec. 205.2.E	Deleted "E. Quality Improvement

Organization (QIO-like vendor) Medicaid's QIO for payment authorization may be contacted at the following addresses and phone numbers: First Health Services Group 4300 Cox Road Glen Allen VA 23060 (804) 965-7400 http://www.fhsc.com The QIO may also be reached on-line. Payment Authorization Forms are available on the website as well."

Sec. 205.3

Deleted "FORMS"

Deleted "NOT SUPPLIED BY MEDICAID"

Deleted "Forms used by the hospital for billing purposes and not supplied by Nevada Medicaid are listed below: a. UB-92-Acute hospital patient billing form. Hospitals may order this form from any stationary supply store: b. CMS (HCFA) 1500 – Health insurance billing form. Forms following the sequence of the HCFA 1500 are acceptable. Providers may order this form from a private printer or purchase from: Government Printing Office Superintendent of Documents Room C836, Building G Washington, D.C. 20401"